eHealth Workgroups
Coordinating Tasks and Background Information
DRAFT 4/17/06

This document covers:
1. Assumptions about the process (page 1 - 3)

2.   A chart that maps how assignments are coordinated across the groups (page 4 – 6)

3.   A listing of possible initiatives for the Patient Care and Consumer Interests Groups to evaluate, add to if they wish, and prioritize (page 7 - 9)

4. Background information for the technical exchange workgroup's consideration (page 10 - 11)
   ▪ List of common set of infrastructure needs
   ▪ Feasibility considerations for each technology/exchange objective
   ▪ Geographical and participation considerations

5. Issues to consider in addressing governance (page 12 - 15)

Assumptions:

1. It is important to distinguish the different, but related concepts of HIT (info technology built inside an enterprise) and HIE (exchange of interoperable information between organizations), understanding that the state roadmap must address both but will probably approach them differently in terms of financing and implementation strategies.

2. Both the Patient Care and Consumer Interests groups should determine which problems are most urgent to solve. This helps invest them in the importance of the project (if we tell people which problems need solving, they'll assume we are pushing "our" solution over "their" needs). Nevertheless, issues of the lack of electronic interoperable information, issues related to financial sustainability, issues related to confidentiality and security, and issues related to current technical infrastructure then

cause the planning effort to work backwards to work on some more basic solutions that nevertheless are clear building blocks for attacking the big consensus problems. The process should facilitate this shared learning process by all participants.

Once both groups have identified the priority areas, the Information Exchange group will assess the feasibility of each. With this information, a matrix can be constructed to show the results. This is the approach used by Arizona for their roadmap and it is a helpful way to approach a complex set of issues. (The Arizona report is published at http://www.azgita.gov/tech_news/2006/4_5_06.htm)

Roadmap Prioritization based on both urgency and feasibility

	High Feasibility	Low Feasibility
High Urgency	Early (Years 1-2)	Mid (Years 3-5)
Low Urgency	Mid (Years 3-5)	Late (Beyond 5)

3. As the issue of statewide versus local development may be confusing, one way to approach this is to ask the Finance group to explore what are the most "natural" medical trading areas in the state, which then allows people to think concretely about what types of "local" initiatives make the most sense. This can help people explore how issues about local trust and economic relationships may provide more a useful scale for many solutions that might stall at the statewide level.

4. Timing-wise, the Governance work group (late in the process) will figure out what type of statewide organization is needed above and beyond the eHealth Board, and what the relationship between those two organizations and local initiatives should be.

5. Each group has work to do now so no one is sitting idle or waiting for others.

6. An orientation for all workgroup members and resource people will be provided in the form of one briefing document for all that can be supplemented by presentations to specific workgroups tailored to their responsibilities.

7. Board chair Helene Nelson and workgroup chairs will have a monthly conference call to monitor progress and the interaction of work across the groups. Staff will attend all workgroup meetings and monitor all workgroup activities to assure coordination and progress.

8. Workgroups will each have about 5 – 7 members and resource people will be identified for each group to provide technical support.

9. Workgroup chairs will set the meeting schedule for the group.

10. In terms of roles and responsibilities, here is what Michigan has set up for the process they are just starting:

Chairpersons

*   Project oversight and approval of recommendations
*   Leads group
*   Prepares meeting content
*   Participates in pre-meeting calls
*   Assures that the deliverables are being completed

Facilitators

*   Provides national and industry content
*   Ensures workgroup is on track
*   Participates in pre-meeting calls
*   Reviews deliverables being completed

Staff

*   Coordinates meeting-to-meeting tasks
*   Assists workgroup chair and facilitator
*   Manages logistics and preparation of meeting materials
*   Documents meeting notes
*   Delivers frequent communications and pre-meeting materials

2. eHealth workgroups – Coordination of activities

Timing	Tasks	Patient Care	Information Exchange Technical Requirements	Consumer Interests	Finance	Governance	eHealth Board members	Staff
Late April	1. Orient all workgroup participants to:							
	A. Charge to eHealth Board and Workgroups	X	X	X	X	X		Susan
	B. Roles of workgroup leaders, means of communications(directories, Web worksite)	X	X	X	X	X		Susan, Donna, Seth
	C. Basic definitions and concepts (e.g., HIT versus HIE, medical trading area, etc.)	X	X	X	X	X		Seth, Larry
	D. National planning efforts	X	X	X	X	X		Seth, eHI
	E. Lessons learned from other statewide initiatives	X	X	X	X	X		Seth, eHI
	E. Current Wisconsin initiatives (brief inventory overview).	X	X	X	X	X		Susan
May	2. Initiate assessments required by HIPSC grant			X				Susan, Donna
May	3. Determine approx. "medical trading areas" [1] for Wisconsin				X			Larry, Seth, Donna

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[1] A term used in the Arizona report – they assume that many Health Information Exchange projects will be developed in the context of a medical trading area – a geographic area defined by where a population cluster receives its medical services. (see page 17 of the Arizona RoadMap report at http://www.azgita.gov/tech_news/2006/4_5_06.htm)

Timing	Tasks	Patient Care	Information Exchange Technical Requirements	Consumer Interests	Finance	Governance	eHealth Board members	Staff
May	4. Establish draft principles for Wisconsin governance and relationships to federal and local initiatives					X		Donna, Seth
May	5. Review categories of current HIT/HIE		X					Seth
May	6. Select highest urgency (points of pain) for action in 5 years	X		X				Donna, Seth, Larry
June-July	7. Propose technical solutions to urgency priorities	X	X					Seth, Larry
June-July	8. Describe common infrastructure needed for technical solutions	X	X					Seth, Larry
Aug	9. Review proposed solutions and infrastructure feasibility for statewide implementation in 5 years	X	X	X	X	X	X	
Aug	9. Review proposed solutions and infrastructure feasibility for local implementation (medical trading areas)	X	X	X	X	X	X	
Aug	10. Select 5 year solutions for (a) statewide infrastructure implementation, (b) full-production local (MTA) implementation and (c) prototype implementation						X	
Sept	11. Draft analysis of start-up		X		X		X	

Timing	Tasks	Patient Care	Information Exchange Technical Requirements	Consumer Interests	Finance	Governance	eHealth Board members	Staff
	and sustainment costs for proposed solutions							
Sept	12. Draft of needed organizational framework for 5 year plan, including eHealth Board, new or existing statewide entity; emphasis on multi-stakeholder engagement and state-local interaction					X		
Oct-Nov	13. Interim privacy and confidentiality solutions plan			X				
Oct	14. Draft business model for sustainment based on multi-stakeholder funding				X			
Oct	15. Refine start-up cost estimates for technical solutions (statewide, local and prototype)		X		X			
Oct	16. Refine operating costs for statewide staffing (governance and coordination)					X		
Oct-Nov	17. Author draft plan from elements submitted by workgroups							X
Nov	18. Review of draft plan by workgroups and Board	X	X	X	X	X	X	
Dec	19. Submit final draft to Board							X

3. Possible initiatives for the Patient Care and Consumer Interests Groups to evaluate, add to if they wish, and prioritize

Objectives	Health Information Technology solutions	Health Information Exchange solutions
Clinical care process improvement (quality and productivity)		
▪ Better access to patient's medical information at the point of care		
▪ Within organization	Electronic health record EHR	
▪ Between service providers and clinicians		Community level results reporting, Order entry
▪ Between providers (e.g., discharge summaries, information set like Continuity of Care Record, referral correspondence)		Secure electronic correspondence, Clinical information exchange (CIE)
▪ Improving coordination of care between hospitals, physicians, and other healthcare professionals	Remote/shared access to electronic health record	Clinical information exchange, case management applications
▪ Visualizing patient progress (e.g. trend graphs)	EHR	CIE
▪ Clinician decision support systems (CDSS), alerts and reminders	Electronic health record, some ePrescribing systems	Import of interoperable CIE information into EHR, community-delivered CDSS
▪ Patient registries for chronic illnesses	Practice registries	Web-linked registries
▪ Improving efficiency of care processes (visits, hospitalizations, etc.)	Process redesign incorporating EHR	Process redesign incorporating HIE
Incentivizing improvement		
▪ Enabling measurement, reporting and benchmarking of quality, safety and cost	EHR mining	Clinical and administrative (claims) information exchange
▪ Enabling pay for performance systems for care improvement	ERH mining and reporting	Clinical and administrative (claims) information exchange
Safety		
▪ Reducing medical injuries through better	EHR	CIE

Objectives	Health Information Technology solutions	Health Information Exchange solutions
access to patient clinical information		
▪ Reducing medical injuries through information legibility, accessibility and verification	e-Prescribing, HER, CPOE, Patient ID (bar-code, RFID)	CIE, CIE with CPOE
▪ Reducing medical injuries through automated alerts and decision support	e-Prescribing, HER, CPOE	Import of interoperable CIE information into HER, CIE with CPOE
▪ Facilitating post-marketing surveillance and safety alerts (device or drug registries)	Registries	Linked registries
Reducing Direct Clinical Costs		
▪ Avoiding duplicative medical procedures	EHR, CPOE	CIE
▪ Improving clinician and patient cost-awareness and alternatives (e.g., prescribing alternatives)	EHR, CPOE with CDSS, some ePrescribing systems	CIE with CPOE and CDSS
Patient efficacy and patient-provider communication		
▪ Enabling patient access and use of personal health records	EHR with patient access portal, patient-held cards	CIE with patient access portal or providing info to practice EHR and portal
▪ Patient reminders, recall and decision support	EHR, registries	
▪ Enabling asynchronous patient-provider communications	Email, secure email, secure websites	
▪ Communication of patient information and preferences (e.g., advanced directives, medication list, emergency contacts)	EHR	CIE
Administrative Costs and Tools		
▪ Reducing costs associated with maintaining records	EHR	
▪ Reducing costs associated with transmitting or sharing records	EHR	Results delivery, secure correspondence, CIE
▪ Improving efficiency of claims	EHR-billing link	Clinical and administrative (claims)

Objectives	Health Information Technology solutions	Health Information Exchange solutions
submission, resolution and reimbursement		information exchange
▪ Reducing costs associated with creating records and correspondence (e.g., return to work clearance, sports participation examinations, immunization records)	EHR	Form standardization, secure correspondence
▪ Reducing cost and improving quality of administrative reports and dashboards	HER/MIS links	Clinical and administrative (claims) information exchange
Facilitate Access		
▪ Improve program/service eligibility determination		Eligibility portal
▪ Improve enrollment in health programs (e.g., BadgerCare)	Screening program	Enrollment portal
Public/population health		
▪ Public health/disaster situational awareness and response (includes public health-provider communications)	Health Alert Network	Health Alert network including interoperable info for EHRs
▪ Improving routine public health surveillance (disease, need, utilization, etc.)	Electronic Laboratory Reporting	Syndromic surveillance, CIE mining, resource dashboards
▪ Improved resource planning and management		CIE mining, resource dashboards
▪ Enabling data query for disease control and emergency management		CIE mining
▪ Health promotion and disease prevention using personal health record	PHR	Interoperable info for PHRs
Research		
▪ Facilitating research in diagnostics, treatment, genetics, health systems	Registries	Linked registries, CIE mining

4. Background information for the consideration of the technical exchange work group:

▪   **Common set of infrastructure needs:**
High speed internet
Portal
User and data sharing agreements
Consent management
User identity management
Patient identity management (Master patient index or record locator)
Security and confidentiality measures
Standards for vocabulary, message structures and entity identification
Implementation guides for use cases
Secure messaging and user directory
Frames for alerting, situational awareness

▪   **Feasibility Considerations for each Technology/Exchange objective:**
General:
1. Are prototypes or production systems already implemented production in WI or elsewhere?
2. Is the objective part of an existing strategic/business plan somewhere in the state?
Clinical:
1. How disruptive of current workflow practices?
2. How valued by clinicians?
3. Number of users requiring training and workflow change?
4. Necessity of clinical personnel to perform additional data entry?
5. Proportion of users/data needed to achieve utility (i.e., to be "worth using")?
Technical:
1. What technolog(ies) must be implemented for end users?
2. Does information exist already in electronic form?
3. Is there a need for major data normalization?
4. Do appropriate standards (vocabulary, message structures and entity identification, secure communications infrastructure) exist?

5. Do implementation specifications for the specific use case exist?
6. What intermediate technologies or management needed (e.g., user identity mgmt.)
7. Centralization or distribution of information storage and management
Patient concerns:
1. Will privacy and data use concerns outweigh perceived benefits?
2. Do legal or regulatory barriers need changing?
3. Is patient consent or opt-out a necessary step for this objective?
4. Are confidentiality and security systems adequate to encourage data sharing?
Financial:
1. Availability of capital or start-up funds
2. Business case (are cost-savings or earnings sufficient for sustainment)?
3. Competing/emerging products in the market space
4. Will savings or earnings reach those who must invest time and money?
5. What incentives may be needed to proceed?
Governance:
1. Who controls information access and use?

- **Geographic and participation considerations**

Geographic scope of various objectives/infrastructure:
What objectives (and infrastructure) are appropriately implemented at the statewide level versus the regional (medical exchange area) level?   Based on:
1. need for face-to-face interaction, service
2. need for face-to-face trust
3. economic relationships (frequency and value of exchange)
4. economies of scale
Appropriate local scale: What are the "medical trading areas" within which most day-to-day clinical communications must occur?
Exclusivity: To what extent should exchange projects devoted to limited participants (e.g., specific payer or provider groups) be supported by statewide effort, as opposed to everyone-welcome exchanges? [Prototypes focused on limited participants but planned for long-term universal use might be acceptable either way.]

5. Governance Issues (Draft - Seth Foldy, 4-15-06)

Answering the following questions will help define desirable governance structures.

A. Critical governance roles[2]
Keep these in mind throughout the process. Which are critical for a statewide governance organization, as opposed to local health information exchange organizations?

1. Recruiting, engaging and building trust among key stakeholders.
2. Philosophical integrity (principles, ethics, equity).
3. Vision and strategic planning.
4. Fiduciary responsibility and compliance oversight (audit function).
5. High level development and execution of business plan.
6. High level development and execution of technical plan.
7. Hiring or contracting for and overseeing executive leadership.
8. Establishing policies, standards and agreements.
9. Balancing competing agendas, resolving or refereeing disputes.
10. Fundraising.
11. Enlisting allies and leaders (including government) to overcome obstacles and maintain momentum.
12. Communicating, educating and marketing.

Many of these functions demand considerable staff support (see footnote) which brings up the role of hired staff versus partner organization staff.

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[2] Note that these are distinct from the Executive Role, which *staffs* these function with an eye toward
1. refining and executing strategic, business and technical plans
2. managing governance, fiscal, administrative, compliance and technical systems
3. stakeholder and public communications

Some of these functions may be more critical than others in a given setting. Some inevitably need to be balanced against each other (e.g. engaging stakeholders ("participatory") versus establishing standards ("decisive")).

B. Stakeholders needing Board representation
1. List the *critical* stakeholders in the HIE (without them the HIE could not function), e.g.:
   a. Those who must pay
   b. Those who must implement[3]
   c. Those who must consent
   d. Those who must contribute data[4]
2. List desirable stakeholders, e.g.:
   a. Those who might contribute
   b. Those who could make life easier
   c. Those with specific expertise (legal, finance, marketing, etc.)[3]
3. What is the smallest number of stakeholder representatives that makes sense given 1 and 2? (The larger a governance board, the more unwieldy.)

C. Existing organizations
1. Is there an existing organization that has a highly complementary mission and vision and contains most of the necessary stakeholders (or could create a subsidiary board giving the necessary stakeholders necessary autonomy?
2. If yes: do you really need to create another organization?

D. Selecting the appropriate organization structure.
Different structures have advantages and disadvantages in any given setting for accomplishing the Critical Governance Roles. Some Roles may also be more critical in one setting than another. Consider each of the following structures in light of how your community seeks to fulfill Critical Governance Roles:[5]

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[3] I.e., the clinic adjusting to an EMR, not the firm that physically installs it.

[4] If you can contract to receive data (e.g. RxHub) or services (e.g., legal, marketing) it may become much less important or even a conflict to have them involved in governance.)

[5] A useful grid of details on the ability of different types of organizations to perform various tasks and roles is available at
http://toolkit.ehealthinitiative.org/organization_and_governance/resources.mspx?Section=380&Category=383&Document=347

1. Non-Profit Membership Corporation (Inclusive) (Wisconsin model)
2. Non-Profit Membership Corporation (Limited members) (Mass Health Data Consortium)
3. Non-Profit, Non-Member Corporation (self-perpetuating board)
4. Partnership (Shared services organization, IPA, etc.) (Taconic, Inland Empire)
5. For-Profit Corporation
6. Academic Institution Led (Riegenstrief model)
7. Quasi-Government Organization
8. Government Board (Delaware model)
9. Cooperative or public service corporation

E. Making sure project is governed by leaders.
This is a difficult task to describe and accomplish. The issue is to weed out governors who **primarily** want to increase funding for, or block change that affects, their organization or constituency. Stated positively:
The Board selection process should preferentially select members who:
1. Understand and desire the mission and vision
2. Are proactive problem-solvers
3. Are collaborators
4. Are willing to assume some risk
5. Are used to making decisions for their organization or constituency

The Board selection process should avoid members who:
1. Are hazy about, fear or oppose the mission and vision
2. Are defensive or passive regarding problems
3. Are interested in one sector or organization to the exclusion of others
4. Are risk-averse to the point of paralysis
5. Have little executive decision-making experience or power

This cannot be interpreted as meaning that you avoid all persons who have conflicting views. It may be necessary or important to incorporate those who have issues with the project, but who understand it from an intellectual, clinical and economic perspective and who are able and willing to negotiate.

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Committees
A board of 7-30 people cannot process detail on all the aspects of health information exchange. (Ideally there are no more and no fewer members).

Committees are established (that may include non-board members to broaden the range of technical and stakeholder input) to help process information for the Board.

They should have a clear charge that defines their power and scope, an effective chair, and typically work best if staffed by a non-member (i.e. a staff person). Their work is refined into reports that are delivered to the Board on paper and verbally.

Committees can be "standing" for work that is permanently ongoing or repetitive, and where they play a particularly significant role (usually these are described in the bylaws). Ad hoc committees can be established for specific tasks. The executive committee includes the officers, rarely also committee chairs.

One should not bother much with committee's until one has completed the higher level tasks listed above!

Resources:

The eHealth Initiative Toolbox on Organization and Governance is at
http://toolkit.ehealthinitiative.org/organization_and_governance/default.mspx?

Some particularly useful tools:
Legal issues for RHIO/HIE organizations
http://toolkit.ehealthinitiative.org/organization_and_governance/resources.mspx?Section=380&Category=383&Document=801
http://toolkit.ehealthinitiative.org/organization_and_governance/resources.mspx?Section=380&Category=383&Document=800